

Document 5. Employer Value-Based Insurance Design (VBID) Tool

VBID is an innovative solution to maximizing health outcomes with available health care dollars. The basic premise of VBID is to align consumer incentives and payment strategies with value by reducing barriers to high-value health services and providers (“carrots”) and discouraging the use of low-value health services and providers (“sticks”). When carrots and sticks are used in a clinically nuanced manner, VBID improves health care quality and controls spending growth.

VBID plans are being adopted by many employers and health plans throughout the United States. The Mercer National Survey of Employer-Sponsored Health Plans demonstrates that VBID use is increasing and 81 percent of large employers plan to offer it in the near future. While the basic premise of aligning consumer incentives and payment strategies with value remains consistent, implementation differs across employers and plans.

This tool is designed to assist employers in customizing their VBID offerings. It contains a menu of evidence-based components, and employers may consider offering different combinations of these components to their members, based upon the specific needs of both the employer and the members. These design components were identified by researching publicly available VBID plans, literature, and the US Preventative Services Task Force recommendations.

The tool is designed so that employers can quickly ascertain whether a plan design component they are interested in introducing is a carrot (which reduces barriers to high-value health services or providers) or a stick (which discourages the use of low-value health services and providers). The final column is designed for the employer to take to their insurer or broker when developing a VBID plan to price out the employer’s unique actual cost of implementation.

This is NOT a sample VBID plan. Employers should consider developing their VBID plans based upon an analysis of their member populations.

Step 1: Analyze the health needs of your members*

1. Incentivize members to complete a **health risk assessment** and/or **biometric screening**;
 - A health risk assessment or biometric screening can provide population data to guide the design of a VBID plan by assessing collective risk factors and segmenting the population by certain risk factors and conditions.
 - Programs and incentives can be designed to address the modifiable health risks factors that are most prominent. For example, the health assessment may be greatly beneficial in identifying useful carrots and sticks. It can illuminate disease states or health services that may need to be targeted.
 - However, research shows that a health assessment on its own does not make a real difference to cost or quality. The health assessment must be tied to an active health improvement process such as a health coach, active monitoring by a primary care physician, and/or a wellness contact through the payer.
 - The assessment can serve as part of the baseline data to inform program design and can be repeated periodically to measure progress.
2. Examine **health insurance claims and utilization data**; or
3. Examine workers' compensation claims, evaluate number and reason for sick days (if possible), etc.

*Any and all of these activities can be done in parallel or sequentially, depending on the needs of the business

Step 2: Pick the carrots and sticks that fit the unique needs of your population, as defined by the analysis in Step 1

Plan Design Components		Carrot ¹	Stick ¹	Expected Utilization ²	Cost to Employer
Annual Deductible					
Individual	\$xxxx	May be a carrot if employer provides opportunities for deductible to be reduced	X	Dependent on how used	
Family	\$xxxx	May be a carrot if employer provides opportunities for deductible to be reduced	X	Dependent on how used	
Primary Care/Preventive Services					
Select PCP	\$xxxx reward	X		↑	
Participation in Evidence-Based Disease Prevention/Management programs (for those eligible)	\$100 lower deductible	X		↑	
Well Child Care	No copay	X		↑ dependent on member demographics	
Office Visits	No or low copay	X		↑	
Annual Physical Exam	No copay	X		↑	

Plan Design Components		Carrot ¹	Stick ¹	Expected Utilization ²	Cost to Employer
PCP Visits and Labs for Chronic Disease	No copay	X		↑ dependent on member demographics	
Physical Examinations	No copay	X		↑	
GYN Visits, Mammograms, Pap Tests	No copay	X		↑ dependent on member demographics	
USPSTF recommended Cancer Screening	No copay	X		↑	
Smoking cessation, weight management, other behavioral	No copay	X		↑	
Emergency and Urgent Care					
Urgent Care Center	Low copay	X		↑	
Hospital Emergency Department	High copay (waived if admitted)		X	↓	
Hospital Services^{3,4}					
Outpatient Non-Surgery (Hospital Facility)	Deductible, low copay	X		↑	
Outpatient Surgery (Hospital Facility)	Deductible, high copay (facility fee)		X	↓	
Outpatient Surgery (Freestanding Facility)	Low-mid copay	X		↑	

Plan Design Components		Carrot ¹	Stick ¹	Expected Utilization ²	Cost to Employer
Outpatient Physician Services	No or low copay	X		↑	
Inpatient Physician Services	Deductible, low copay	X		neutral	
Additional Cost Tiers					
+\$100 Copay	Fee waived for some patients	X		↓	
+\$500 Copay	Fee waived for some patients	X		↓	
Prescription Drugs					
Note: Prescription drugs should be personalized at the company level based on the health needs and preferences of employers and members. Businesses may want to consider tiering drugs by value (e.g. life-prolonging, life-saving, quality) as opposed to cost, as is listed below.					
Generic Drugs	No charge	X	May be a stick if "no charge" is related to completion or participation in some sort of program	↑	
Preferred Brand Name Drugs	Low charge	X	May be a stick if "low charge" is related to completion or participation in some sort of program	neutral	
Non Preferred Brand Name Drugs	High charge		X	↓	

- [1] Certain plan designs may be carrots or sticks depending on how they are administered. For example, if an employee is required to participate in a program (i.e. MTM) before receiving reduced copays, then the plan could be considered a stick to employees who are not participating in the program and a carrot for those who are.
- [2] There is evidence that lowering worker payments for certain treatments will slow medical spending over time, but in the short run, such policies might raise employee utilization, because employees are more likely to take their medications and make use of other proven treatments and tests.
- [3] Policy consideration: require higher copays for certain surgeries and diagnostic tests that may be less valuable/medically necessary.
- [4] Includes substance use/mental health hospitalizations

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